DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 03-010

2. STATE: Wisconsin

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
08/15/03

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.331

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 - $2,328K
b. FFY 2005 - $2,837K

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1A, Supplement 1, pp. 6, 6a, 6b	Attachment 3.1A, Supplement 1, pp. 6
Attachment 3.1B, Supplement 1, pp. 5, 5a, 5b, 6	Attachment 3.1B, Supplement 1, pp. 5, 6.
Attachment 4.18A, pp. 3 and 11	Same
Attachment 4.18C, pp. 3 and 11	Same
Attachment 4.19-B, p. 5	Same
Attachment 4.19-B, Supplement 1, Page 1	Same

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Wisconsin (03-010)
Approved: 03/19/04
Effective: 08/15/03

10. SUBJECT OF AMENDMENT:

Pharmacy services - copayments and reimbursement rates

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Mark B. Moody

13. TYPED NAME:
Mark B. Moody

14. TITLE:
Administrator, Division of Health Care Financing

15. DATE SUBMITTED:

16. RETURN TO:
Mark B. Moody
Administrator
Division of Health Care Financing
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
9/29/03

18. DATE APPROVED: 3/19/04 03/19/04

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
8/15/03

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED
SEP 29 2003
DMCH - MI/MN/WI

FORM HCFA-179 (07-92)

10. Dental Services. (Continued)

dental implants and transplants; services for cosmetic purposes; overlay and duplicate dentures; precious metal crowns; professional visits; drug dispensing; adjunctive periodontic services; alveoplasty and stomoplasty; and non-surgical temporomandibular joint therapy. Several services are provided only in specified circumstances or as referred through a HealthCheck (EPSDT) screen. For other limitations and a listing of those services requiring prior authorization, see the WMAP Dental Provider Handbook, Part B.

11. Physical Therapy and Related Services. Prior authorization is required for physical and
Eff. occupational therapies, and speech pathology after 35 treatment days per spell of illness. (See ss.
7-1-88 HFS 107.16 (2) through 107.18 (2), Wisconsin Administrative Code.) Services for recipients who are hospital inpatients or receiving therapy through a home health agency are not subject to this requirement. For audiology, prior authorization is required for speech and audiotherapy, aural rehabilitation and dispensing of hearing aids. See s. HFS 107.19.

12.a. Prescribed Drugs.
Eff.
8/15/03 1. Drugs and drug products covered by MA include legend and non-legend drugs listed in the Wisconsin Medicaid drug index, which are prescribed by a licensed physician, nurse prescriber, dentist, podiatrist, or optometrist or when a physician delegates prescription of drugs to a nurse practitioner or to a physician's assistant.

2. Drugs excluded from coverage include drugs determined "less than effective" by the FDA, drugs not covered by a federal rebate agreement, experimental drugs or other drugs that have no medically accepted indications, and other items as enumerated in Wisconsin Administrative Code, HFS107.1(4).

3. To be a covered service, an over-the-counter drug shall have a signed federal rebate agreement with that drug's manufacturer. General categories of OTC drugs that are covered include the following: antacids, analgesics, insulins, contraceptives, cough preparations, proton pump inhibitors (PPI's), anti-histamines, ophthalmic lubricants, iron supplements for pregnant women, and other, medically necessary, cost-effective drug products, including some non-legend products that previously had legend drug status.

12.a. Prescribed drugs, continued.

Prior Authorization

1. Prescription drugs may be subject to prior authorization by DHFS to ensure that drugs are prescribed and dispensed appropriately.

2. DHFS determines which prescription drugs may require prior authorization by reviewing the drug(s) for the following: safety; potential for abuse or misuse; narrow therapeutic index; and high cost when less expensive therapeutically equivalent alternatives are available.

3. DHFS will convene a Prescription Drug Prior Authorization Committee comprised of at least two physicians, two pharmacists, and one advocate for Medicaid recipients to review the pertinent scientific literature and make prior authorization recommendations to the Department.

4. As enumerated in Wisconsin Administrative Code, all Schedule III and IV stimulant drugs as listed in the Wisconsin Medicaid Drug Index; enteral and parenteral nutrition products; fertility drugs used for treatment of a condition not related to fertility; impotence drugs used for treatment of a condition not related to impotence; drugs that have been demonstrated to entail substantial cost or utilization problems for the MA program; and drugs produced by a manufacturer that has not signed a federal rebate agreement but which are medically appropriate and cost effective treatment for a recipient's condition as certified by the prescribing provider are subject to prior authorization.

5. To provide economies and efficiencies in the Medicaid program, the state applies the same prior authorization requirements and supplemental rebate provisions utilized in the Medicaid program to its state-sponsored portion of SeniorCare.

12.a. Prescribed drugs, continued.

6. Prior authorization programs for covered outpatient drugs provide for a response within 24 hours of a request for prior authorization and for the dispensing of a 72-hour supply of medications in emergency situations.

7. A drug use review program, including prospective and retrospective drug utilization review, has been implemented, in compliance with federal law.

8. Claims management is electronic, in compliance with federal law.

9. The state is in compliance with section 1927 of the Social Security Act. The state will cover drugs of manufacturers participating in the federal rebate program. The state is in compliance with reporting requirements for utilization and restrictions to coverage. Pharmaceutical manufacturers may audit utilization data. The unit rebate amount is confidential and may not be disclosed for purposes other than rebate invoicing and verification.

10. The state will negotiate supplemental rebates in addition to federal rebates provided for in Title XIX. Rebate agreements between the state and a pharmaceutical manufacturer will be separate from the federal rebates. Supplemental rebates received by the state in excess of those required under the federal drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the federal rebate agreement.

11. A rebate agreement between the state and a drug manufacturer for drugs provided to the Medicaid program, submitted to CMS on 1/30/04 and entitled, "State of Wisconsin Supplemental Rebate Agreement," has been authorized by CMS.

12. Pursuant to 42 USC 1396r-8, the state is establishing a preferred drug list with prior authorization requirements for drugs not included on the preferred drug list.

10. Dental Services. Dental services are limited to the basic services within each of the following
Eff. categories: diagnostic services, preventive services, restorative services, endodontic services,
10-1-95 periodontic services, fixed and removable prosthodontics, oral and maxillofacial surgery services, and emergency treatment of dental pain. The following are examples of services not covered: dental implants and transplants; services for cosmetic purposes; overlay and duplicate dentures; precious metal crowns; professional visits; drug dispensing; adjunctive periodontal services; alveoplasty and stomoplasty; and non-surgical temporomandibular joint therapy. Several services are provided only in specified circumstances or as referred through a HealthCheck (EPSDT) screen. For other limitations and a listing of those services requiring prior authorization, see the WMAP Dental Provider Handbook, Part B.

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Eff. occupational therapies, and speech pathology after 35 treatment days per spell of illness. (See ss.
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12.a. Prescribed Drugs.
Eff.
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2. Drugs excluded from coverage include drugs determined "less than effective" by the FDA, drugs not covered by a federal rebate agreement, experimental drugs or other drugs that have no medically accepted indications, and other items as enumerated in Wisconsin Administrative Code, HFS 107.1(4).

3. To be a covered service, an over-the-counter drug shall have a signed federal rebate agreement with that drug's manufacturer. General categories of OTC drugs that are covered include the following: antacids, analgesics, insulins, contraceptives, cough preparations, proton pump inhibitors (PPI's), anti-histamines, ophthalmic lubricants, iron supplements for pregnant women, and other, medically necessary, cost-effective drug products, including some non-legend products that previously had legend drug status.

12.a. Prescribed drugs, continued.

Prior Authorization

1. Prescription drugs may be subject to prior authorization by DHFS to ensure that drugs are prescribed and dispensed appropriately.

2. DHFS determines which prescription drugs may require prior authorization by reviewing the drug(s) for the following: safety; potential for abuse or misuse; narrow therapeutic index; and high cost when less expensive therapeutically equivalent alternatives are available.

3. DHFS will convene a Prescription Drug Prior Authorization Committee comprised of at least two physicians, two pharmacists, and one advocate for Medicaid recipients to review the pertinent scientific literature and make prior authorization recommendations to the Department.

4. As enumerated in Wisconsin Administrative Code, all Schedule III and IV stimulant drugs as listed in the Wisconsin Medicaid Drug Index; enteral and parenteral nutrition products; fertility drugs used for treatment of a condition not related to fertility; impotence drugs used for treatment of a condition not related to impotence; drugs that have been demonstrated to entail substantial cost or utilization problems for the MA program; and drugs produced by a manufacturer that has not signed a federal rebate agreement but which are medically appropriate and cost effective treatment for a recipient's condition as certified by the prescribing provider are subject to prior authorization.

5. To provide economies and efficiencies in the Medicaid program, the state applies the same prior authorization requirements and supplemental rebate provisions utilized in the Medicaid program to its state-sponsored portion of SeniorCare.

12.a. Prescribed drugs, continued.

6. Prior authorization programs for covered outpatient drugs provide for a response within 24 hours of a request for prior authorization and for the dispensing of a 72-hour supply of medications in emergency situations.

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11. A rebate agreement between the state and a drug manufacturer for drugs provided to the Medicaid program, submitted to CMS on 1/30/04 and entitled, "State of Wisconsin Supplemental Rebate Agreement," has been authorized by CMS.

12. Pursuant to 42 USC 1396r-8, the state is establishing a preferred drug list with prior authorization requirements for drugs not included on the preferred drug list.

12.b. Dentures. Prior authorization is required.

12.c. Prosthetic Devices. Prior authorization is required for most prostheses, hearing aids, and other
Eff. medical equipment in the Wisconsin Durable Medical Equipment and Supplies indices, except
1-1-93 for certain opthalmological prostheses Prior authorization also is required for most items not in the indices

12.d. Eyeglasses. When frames and lenses services are provided by the same provider, prior
Eff. authorization is required to exceed the following limitations in a 12 month period: one original
1-1-93 pair; one unchanged prescription replacement pair; and one replacement pair with a documented changed prescription meeting Department criteria. Tinted lenses, occupational frames, certain glass and lens types and frames and other vision materials not obtained through the volume purchase plan also require prior authorization. Anti-glare coating, spare eyeglasses and sunglasses, and services provided primarily for convenience or cosmetic reasons are not covered.

13.d. Rehabilitative Services.
Eff.
1-1-93 Community Support Program Services. Community Support Programs (CSP) provide a compendium of medical and psychosocial rehabilitative services, enabling the recipient to better manage the symptoms of his/her illness, to improve independence, and to achieve effective levels of functioning in the community. Recipients able to benefit from mental health treatment and restorative services provided in a community setting on a long-term basis will experience a reduction in the incidence and duration of institutional care they might otherwise need.

Service	Type of Charge			Amount and Basis for Determination
	Deductible	Coinsurance	Copayment	
DRUGS AND DISPOSABLE MEDICAL SUPPLIES				
Legend Drugs, OTCs, Disposable Medical Supplies (Except Family Planning Items)			X	$3.00 per each new and refill legend brand name drug prescription and $1.00 per each new and refill legend generic drug prescription up to $12.00 per pharmacy per recipient per month. $0.50 per item for each new and refill OTC drug prescription and disposable medical supply. (No monthly limit for OTCs or disposable medical supplies.)
DURABLE MEDICAL EQUIPMENT				
Durable Medical Equipment Purchase			X	Based on maximum allowable fees: • Up to $10.00 $0.50 • From $10.01 to $25.00 $1.00 • From $25.01 to $50.00 $2.00 • Over $50.00 $3.00 Note: SFY03 average WI Medicaid DME purchase payment was $123.19.
EPSDT (HealthCheck)			X	$1.00 per screening for recipients age 18 and over.
GLASSES				
Dispensing Complete Appliance			X	$3.00 per procedure.
Frame, Temple, or Lens Replacement			X	$2.00 per procedure.
Repair Service			X	$0.50 per procedure.

The following limits and cumulative maximums on copayments apply:

1. Prescriptions for legend drugs beyond a total of $12.00 copayment per calendar month if the recipient uses a single pharmacy as their sole provider of prescription drugs.

2. Outpatient psychotherapy services over 15 hours or $500.00 per equivalent care, (whichever comes first) per recipient per calendar year. This equates to a maximum of $30.00 copayment per recipient per calendar year.

3. Occupational, physical or speech therapy services over 30 hours or $1,500.00 of equivalent care (whichever comes first), per therapy type, per recipient, per calendar year. This equates to a maximum of $60.00 copay per therapy type, per recipient, per year.

4. Physician, podiatrist and nurse practitioner visits, laboratory, radiology, diagnostic tests, rural health clinic visits, surgery over $30.00 per recipient per provider, per recipient, per calendar year.

5. Inpatient hospital and inpatient stays in institutions (hospitals) for mental disease services beyond $75.00 per stay.

6. Wisconsin Medicaid automatically deducts applicable copayment amounts from Medicaid payments. However, both the point of sale system and the mainframe are "hard-coded" to exempt and limit copayments using criteria included on this page. All providers who perform services that require recipient copayment must make a reasonable attempt to collect that copayment from the recipient. However, providers may not deny services to a recipient for failing to make a copayment.

The following recipient groups are exempt from copayments by Federal and/or State law:

1. Persons under 18 years of age.
2. Nursing home residents.
3. Pregnant women, for services related to the pregnancy or to any other medical condition that may complicate the pregnancy.
4. Institutionalized individuals, i.e., individuals who are inpatients in a hospital, long term care facility, or other medical institution if the individual is required as a condition of receiving services in the institution, to spend all but a minimal amount of his/her income required for personal needs, for medical care costs.
5. Family planning services and related supplies.
6. Emergency Services.
7. Recipients who are a member of a health maintenance organization (HMO).

Service	Type of Charge: Deductible	Coinsurance	Copayment	Amount and Basis for Determination
DRUGS AND DISPOSABLE MEDICAL SUPPLIES				
Legend Drugs, OTCs, Disposable Medical Supplies (Except Family Planning Items)			X	$3.00 per each new and refill legend brand name drug prescription and $1.00 per each new and refill legend generic drug prescription up to $12.00 per pharmacy per recipient per month. $0.50 per item for each new and refill OTC drug prescription and disposable medical supply. (No monthly limit for OTCs or disposable medical supplies.)
DURABLE MEDICAL EQUIPMENT				
Durable Medical Equipment Purchase			X	Based on maximum allowable fees: • Up to $10.00 $0.50 • From $10.01 to $25.00 $1.00 • From $25.01 to $50.00 $2.00 • Over $50.00 $3.00 Note: SFY03 average WI Medicaid DME purchase payment was $123.19.
EPSDT (HealthCheck)			X	$1.00 per screening for recipients age 18 and over.
GLASSES				
Dispensing Complete Appliance			X	$3.00 per procedure.
Frame, Temple, or Lens Replacement			X	$2.00 per procedure.
Repair Service			X	$0.50 per procedure.

The following limits and cumulative maximums on copayments apply:

1. Prescriptions for legend drugs beyond a total of $12.00 copayment per calendar month if the recipient uses a single pharmacy as their sole provider of prescription drugs.

2. Outpatient psychotherapy services over 15 hours or $500.00 per equivalent care, (whichever comes first) per recipient per calendar year. This equates to a maximum of $30.00 copayment per recipient per calendar year.

3. Occupational, physical or speech therapy services over 30 hours or $1,500.00 of equivalent care (whichever comes first), per therapy type, per recipient, per calendar year. This equates to a maximum of $60.00 copay per therapy type, per recipient, per year.

4. Physician, podiatrist and nurse practitioner visits, laboratory, radiology, diagnostic tests, rural health clinic visits, surgery over $30.00 per recipient per provider, per recipient, per calendar year.

5. Inpatient hospital and inpatient stays in institutions (hospitals) for mental disease services beyond $75.00 per stay.

6. Wisconsin Medicaid automatically deducts applicable copayment amounts from Medicaid payments. However, both the point of sale system and the mainframe are "hard-coded" to exempt and limit copayments using criteria included on this page. All providers who perform services that require recipient copayment must make a reasonable attempt to collect that copayment from the recipient. However, providers may not deny services to a recipient for failing to make a copayment.

The following recipient groups/services are exempt from copayments by both Federal and State law:

1. Persons under 18 years of age.
2. Nursing home residents.
3. Pregnant women, for services related to the pregnancy or to any other medical condition that may complicate the pregnancy.
4. Institutionalized individuals, i.e., individuals who are inpatients in a hospital, long term care facility, or other medical institution if the individual is required as a condition of receiving services in the institution, to spend all but a minimal amount of his/her income required for personal needs, for medical care costs.
5. Family planning services and related supplies.
6. Emergency Services.
7. Recipients who are a member of a health maintenance organization (HMO).

3. Drugs (Pharmacy)

The Department will establish maximum allowable fees for all covered pharmaceutical items and disposable medical supplies provided to Wisconsin Medicaid recipients eligible on the date of service. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law (42 CFR 447.331).

All covered legend and over-the-counter drugs will be reimbursed at the lower of the Estimated Acquisition Cost (EAC) of the drug, plus a $4.88 dispensing fee, or the provider's usual and customary charge.

EAC of legend and over-the-counter drugs will be determined based on the following:

> The Department of Health and Family Services' best estimate of prices currently and generally paid for pharmaceuticals. Individual drug cost estimates will be based on either Maximum Allowed Costs (MAC), established by Wisconsin Medicaid using marketplace research; or discounted published average wholesale prices. The discounted published average wholesale price will be determined by applying a twelve percent discount to the AWP as listed in the First Data Bank Blue Book (AWP minus 12%). Effective July 1, 2004, the discounted published average wholesale price will be determined by applying AWP minus 13%.

Drug costs will be calculated based on the package size from which the prescription was dispensed, as indicated by the NDC. The only exceptions are for those drugs for which quantity minimums are specified by federal regulations and for drugs listed on the Wisconsin MAC list.

The maximum allowable dispensing fee shall be based on allowed pharmacy overhead costs and determined by various factors, including data from previous cost of dispensing surveys and other relevant economic limitations.

Wisconsin Medicaid
Maximum Allowed Pharmacy Dispensing Fee Schedule[1]

Per-Prescription Drug Payment Reduction (Effective 07/01/95)	$0.50/prescription dispensed
Traditional Dispensing Fee (Effective 07/01/98)	$4.88
Dispensing Allowance for Re-Packaging (Effective 04/01/97)	$0.015/unit

Estimated Acquisition Cost (EAC) Calculation

Legend Drugs and Covered Over-the-Counter (OTC) Drugs	Average Wholesale Price (AWP) minus 12% eff. 8/15/03; AWP minus 13% eff. 7/1/04 or Maximum Allowed Cost (MAC)

Compound Drug, Time Allowance

Level	Time	Fee
11	0-5 minutes	$ 9.45
12	6-15 minutes	$14.68
13	16-30 minutes	$22.16
14	31-60 minutes	$22.16
15	61+ minutes	$22.16

Pharmaceutical Care Dispensing Fees

Level	Time	Fee
11	1-5 min.	$ 9.45
12	6-15 min.	$14.68
13	16-30 min.	$22.16
14	31-60 min.	$40.11
15	61+ min	$40.11

1 Providers must bill Wisconsin Medicaid at an amount not in excess of the usual and customary charge billed to non-Medicaid recipients for the same service.